



Report to the Legislature

Report on Homecare Health Options

Chapter 372, Laws of 2006 (ESSB 6386, Section 206)

October 2006

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Executive Summary

This Report on Homecare Health Options is a response to a legislative proviso in Chapter 372, Laws of 2006 (ESSB 6386, Section 206), which reads:

The Department of Social and Health Services (DSHS) in consultation with the home care quality authority and the health care authority shall examine how the state determines the appropriate level of health care costs when establishing state contribution rates for all agency and individual home care workers caring for state subsidized clients. The department shall recommend options as to how equivalent benefits can be purchased on behalf of home care workers in a more cost effective manner to the office of financial management and the appropriate fiscal committees of the legislature by October 1, 2006.

This report is based on review of recent environmental changes and conversations with stakeholders, including DSHS management at all levels, representatives from the Home Care Quality Authority, the Health Care Authority (HCA), legislative staff, the Office of Financial Management (OFM) labor negotiator, and homecare agency providers. Three options, none of which are mutually exclusive, appear to be the most relevant for this report. They are:

1. Reinstating a mandated benefit level.
2. Mandating group purchasing.
3. Enhancing capacity to effectively bargain cost effective rates for homecare through better research into alternative plans and cost modeling.

Introduction and Background

The entire homecare workforce presents a particular insurability challenge. It is an older workforce largely made up of women, and as such, represents a pool that is considered high risk, generally costs more, and consequently may not be attractive to insurers. The statewide nature of the workforce is also a factor in insurability and cost as plans vary according to population densities and availability of insurers. Private sector homecare agencies and consumer-employers of individual providers (IPs) report that offering good health insurance benefits helps them retain workers. Workers report that health insurance benefits are one way they decide where to work. Not surprisingly, workers also report

that if health insurance were not offered by a particular agency, they would seek employment where it was offered.

At the same time, for a variety of reasons, a number of potentially eligible workers do not enroll. The biggest factors include Medicare and/or Medicaid coverage, or coverage through private insurance plans offered through another employer or a spouse. Approximately 23,500 IPs are contracted through the State to provide care for Medicaid clients. Of these, approximately 4,400 are enrolled in health insurance through the Trust. There are currently 89 homecare agencies providing services to state funded clients in Washington that employ approximately 5,100 homecare workers that are eligible to receive health care benefits. Of these eligible employees, approximately 3,700 (72%) actually receive health insurance benefits. In the last year, IP health care enrollment has increased 44%, from 3,070 in July 2005 to 4,400 in July 2006; agency employee enrollment has increased 5%, from 3,530 in July 2005 to 3,700 in July 2006.

The impact of unionization in homecare is significant and growing. SEIU Local 775 represents the entire 23,500-member IP workforce. Fourteen of the homecare agencies are unionized: eight through OPEIU Local 8, and six through SEIU Local 775. Overall, 87% of the workers potentially eligible for health benefits are covered under some form of labor agreement. IPs and many unionized agency workers working more than 20 hours per week are currently eligible to be insured on a group basis through a Taft-Hartley Trust. The Trust was established specifically to purchase healthcare benefits for unionized employees pursuant to the SEIU collective bargaining agreement, and is largely funded by State dollars. By federal law, Taft-Hartley Trusts are managed jointly by employer and union representatives. In this case, because the State is in the unique position of being the employer of IPs only for the purpose of collective bargaining, the State is not a trustee of the fund. The Trust is thus governed by a board made up of SEIU Local 775 and homecare agency representatives.

As of July 2006, the Trust carriers insure approximately 6500 workers: 4,400 IP enrollees and 2,100 agency provider enrollees. Agency employees may also enroll their dependents, usually at their own cost. The State pays the Taft-Hartley Trust per enrolled member on a monthly basis. Homecare agencies submit a separate billing for health insurance for each enrolled worker for reimbursement from the Area Agencies on Aging or the Division of Developmental Disabilities of Aging and Disability Services Administration. This is a separate and distinct payment from their hourly vendor rate.

Homecare agencies outside of the Taft-Hartley Trust, representing approximately 3,000 eligible workers, are the only members of the Washington homecare workforce who currently obtain private-market health care insurance as individual employers. Of these potentially eligible workers, 1,500 are actually enrolled. As such, the history of agency coverage is important to this discussion.

- Between 1990 and 1995, coverage was based on agency decision and paid as part of the hourly vendor rate. There was no comparable package used among agencies: costs, and therefore benefits, varied widely.
- From 1995 to 1999, contracted agency coverage for eligible employees (those working 20-plus hours) was mandated by statute solely through the Basic Health Plan (BHP). This resulted in comprehensive benefits and cost savings for those employees who met the criteria for the subsidized BHP. For those that did not, employers had to offer the non-subsidized BHP plan, and general funds had to be increased.
- In 2000, the Legislature approved the purchase of BHP-equivalent private market plans for those agencies that opted to do so. This took some enrollees out of BHP and thus changed the cost structure of the BHP. This change was necessary because the non-subsidized BHP was dropped in most areas of the state by insurance carriers. If this change had not been made, approximately 30% of eligible homecare workers would have had no coverage.
- The Taft-Hartley Trust was established in 2003 and began providing health care plans in 2004. Unionized agencies opt to join through collective bargaining and a limited number of other employers can apply to purchase benefits for their employees through the Trust.
- In 2005, DSHS recommended to the Legislature that agency providers be required to join a group purchasing plan, and an attempt was made to find or create a group purchasing option for health insurance for use by homecare agencies that were not participating in the SEIU Taft Hartley Trust. The Legislature instead eliminated the requirement that private market plans had to be equivalent to BHP and set a statewide average cap as a maximum premium level. Because enrollment in the proposed new plan was voluntary, there was not enough guaranteed worker participation and the plan fell through. Thus benefits obtained outside the Trust again began to vary widely in both price and substance. Within the

Trust, there are several benefit plan design choices, although the IPs and most agency home care workers are on the same plan.

- In March 2006, House Bill 2333 was signed into law, mandating parity between bargained IP wages and benefits and those of homecare agency providers. HB 2333 specifically requires that “The contribution rate for health care benefits, including but not limited to medical, dental, and vision benefits, for eligible agency home care workers shall be paid by the department to home care agencies at the same rate as negotiated and funded in the collective bargaining agreement for individual providers of home care services.”

Since the inception of the SEIU Local 775 bargaining unit in 2001 and the subsequent finalized contract in 2003, State contributions toward IP health care have been determined through the collective bargaining process. In Washington, if the union and the State fail to reach agreement at the bargaining table, the contract is subject to binding interest arbitration. This is worth noting because it means that wages, benefits, and any other mandatory subjects at the bargaining table which reach impasse will be finalized by an arbitrator using comparability data from other similar jurisdictions and authorities determined solely by the arbitrator within the parameters of the arbitration statute. Currently, the cap for the state contribution to the cost of health, dental and vision care benefits combined per eligible participating worker per month is \$480 in fiscal year (FY) 2005-2006 and \$532 in FY 2006-2007.

House Bill 2333 ties the maximum State contribution toward health care for agency providers to what is bargained for IPs. In effect, then, IP bargaining and the associated arbitration process determines the State's level of contribution toward healthcare for the entire homecare workforce. Parity legislation was motivated by concern among homecare agencies that the IP bargaining agreement would establish the standard for coverage, and their ability to recruit workers, therefore, depended on keeping financial pace with the IP healthcare award.

Over the long term, those fears are likely to be well founded. The Taft-Hartley Trust has the advantage of a very large pool of eligible workers for health insurance. Such a large pool is attractive to insurance brokers who are able to develop a health insurance plan with lower premiums or much better benefits than what most individual homecare agencies can obtain. The Trust's cost history thus far has been less expensive than anticipated during its first two years of existence. Over time, it is likely that this could have a positive effect on rates. For example, for the first year of the 2007-2009 SEIU contract, the Trust is not requesting any increase in premium, while the Basic Health Plan cost for Calendar Year (CY) 2007 is projected

to increase by 6.3%. Alternatively, a favorable cost history could allow the Trust to provide increased benefits to its members within the current premium level.

Homecare agencies not in the Taft-Hartley Trust must obtain their health insurance on the open market and are much more susceptible to normal health care inflation. Homecare agencies are able to select health insurance coverage they can afford. If the health insurance they purchase costs more than the reimbursement cap, homecare agencies must absorb the cost or pass on the cost to their workers.

The State average reimbursement rate for homecare agency providers was well below the cap at \$391 in May 2006, ranging from \$369 for agencies in the Southwest Area Agency on Aging to \$423 for agencies in the Central Washington Area Agency on Aging. Only three homecare agencies were reimbursed the maximum allowed (two in King County Area Agency on Aging and one in Snohomish County Area Agency on Aging). Since each agency is free to determine its own range of benefits, consistency in the types of services covered and co-pays for homecare agency workers varies widely from agency to agency.

Because of their limited purchasing power with carriers, the agencies that are not part of the Taft-Hartley Trust or some other group purchasing arrangement will be more likely to experience higher inflationary costs. The Trust will most likely work to keep insurance costs down for its covered lives, while agencies may be subject to growing market rates. For some agencies already bumping up against the rate cap, any reduction in this cap could result in the necessity of purchasing benefits with greater limitations, passing any cost increases on to the workforce by increasing co-pays, or setting a higher deductible that employees must meet before being able to access the benefit. When any of these increases rise above a certain level in a low-wage workforce, usage of a health plan becomes difficult, if not impossible.

Although there are currently differences in the price and scope of services between agencies and IPs, the demographics of the underlying work force, in terms of what matters to insurers, are the same. Consequently, it is expected that the costs will eventually migrate toward the IP maximum and, without external requirements from the Legislature or through bargaining, the scope of benefits will depend on the level of competition for workers between agencies and the level of competition between insurers in local markets.

Up to 20% of the Trust can consist of non-union participants. Although this limit has not currently been met, it is possible that this could provide a future barrier to the enrollment of non-union homecare agencies if they

chose to apply. The Trust currently enrolls all eligible IPs and unionized agencies that have bargained to participate. The Trust must approve the non-union applicants. Currently there are two union trustees from SEIU and two employer trustees from Addus Homecare, a national homecare agency.

During the course of meeting with stakeholders about this legislative proviso, two areas of discussion needing clarification emerged. The first was the use of the Basic Health Plan (BHP) as an insurance option for homecare workers; the second was the idea of folding insurance costs into the agency vendor rate.

Basic Health Plan

The BHP has been used to insure a portion of the homecare workforce. According to the Health Care Authority, enrolling more homecare agency workers in the Basic Health Plan is not a viable option. The plan now has over 100,000 other non-homecare enrollees whose premiums would be negatively affected if the agency providers were to be allowed in due to the demographics of that workforce. Basic Health is individual insurance coverage. Families pay a separate premium for each family member covered by the program. Employers may sponsor employees. However, the BHP is limited in who it is able to insure in terms of income level, Medicare eligibility, and state residence. Basic Health statutes require enrollees to be state residents and enrollees are not eligible for Basic Health if they are eligible for Medicare. While Basic Health statutes provide for both subsidized and nonsubsidized (over the 2005 Federal Poverty Level) coverage, the nonsubsidized program is nonexistent, as health carriers no longer contract with HCA for nonsubsidized coverage. Thus, Basic Health is not an option to many agencies, which by law may not purchase plans that offer a different set of benefits to employees based on age, income or other criteria that may be viewed as discriminatory. As of September 2006, there are 45 agency workers and 369 IPs still in the BHP, which is still allowed as a coverage option. They have stayed there because the BHP offers more affordable dependent coverage than many of the other options available to them.

As a cost-effective option, it may be possible to develop an insurance program through an alternative modeled for this population. This option is explored later on in this report. A higher standard for benefit levels, reduced co-payments, deductibles, and other out-of-pocket expenditures have been created through the Taft-Hartley Trust. Any future options would thus need to meet or exceed those standards, given the importance placed on them in collective bargaining.

Reimbursing Agencies through Vendor Rates

Currently, homecare agencies are reimbursed for actual health insurance costs up to the maximum allowable cap per eligible employee. It has been suggested that the reimbursement rate be converted into an hourly rate and incorporated into the hourly unit rate homecare agencies now receive. In the September 2006 arbitration process between SEIU and the State, the arbitrator left this decision open. Whatever method of calculation gets used must meet agency parity standards. Averaging the actual agency health care costs and converting that into an hourly rate would not meet these standards, so under existing statute it is not possible to make such a switch. If instead the hourly conversion occurred at the maximum capped rate, as it does for the SEIU IP contract, agencies would benefit, but there would be no cost savings. Without a mandated purchase product and standard premium cost, this change will create “winners” – agencies who are able to purchase insurance for less than the reimbursement and have additional money within their vendor rate to apply to other costs, and “losers”, who, because of demographics or geography, will be forced to pay additional premium costs in order to maintain their contract with the State.

Recommendations

DSHS recommends consideration of the following three options. Implementation of any one of these options does not preclude consideration of the others; in fact, exploration of all three could result in the most effective plan.

Existing System with Addition of Mandatory Benefit Levels

The current system could be improved by mandating implementation of a uniform insurance benefit level. Setting a baseline for insurance benefits would ensure that the scope of benefits is consistent. This would identify a baseline benefit to enable better determination of cost effectiveness and allow for competitive industry bidding in the future. A note of caution: adding a mandatory benefit without being sure the premium cap is reasonably set could have a devastating impact on the ability of some agencies to purchase healthcare. Homecare insurance reimbursement caps will no longer be determined legislatively but will be bargained items in union negotiations. Eligibility will also be on the table to be bargained in union negotiations. Mandating benefits standards will improve the ability of the State to bargain cost effective rates and benefits.

Mandated Group Purchasing

In this scenario, all purchasers would be required to purchase in a group. Employers participating in the Taft Hartley Trust plans would be covered and the homecare agencies not currently within the Taft-Hartley Trust would be required to join an insurance pool to get the best possible rate and more uniform benefits. There may be a few agencies that will not benefit from this arrangement, but it is likely that the majority would.

In 2005, the Washington State Homecare Coalition considered a health insurance pool, whose members would include most of the homecare agencies in Washington, and an insurance broker was retained. The insurance broker worked with an insurance carrier who was willing to provide comparable health insurance at a comparable cost to the Taft-Hartley Trust for all homecare agency employees. The broker did not go forward; since the pool was to be voluntary, it would be inherently unstable as homecare agencies could come and go as they pleased all the while in search of more competitive rates. Some homecare agencies did not want to be a part of the pool, claiming their health care coverage was better than what was going to be offered by the pool. Unionized agencies not in the Trust said they would go into the Trust instead of the independent pool. This demonstrated that without a legislative mandate, any attempt to create a new voluntary pool of agency providers for insurability purposes would not have the momentum to succeed.

Creation of a health insurance pool where all homecare agencies not enrolled in the Taft-Hartley Trust are mandated to participate would result in a larger number of workers from which a carrier could base cost. The parity language gives the homecare agencies the same rate as the Trust. The pool of workers outside the Trust is much smaller, so the insurance the carrier could provide might end up offering less coverage and/or costing more than what is offered in the Trust.

Create Alternative New Product

The third option is the creation of a competitive alternative insurance option to the Taft-Hartley Trust. Since the health benefit market for the entire homecare industry is set in SEIU IP bargaining, the State could improve its ability to bargain more effectively by mirroring the approach to bargaining health insurance that is used in other collective bargaining contexts. That requires enhancing the State's ability to identify comparable cost and plans for a particular set of benefits in setting the context for other terms of bargaining over health benefits.

Exploration of this option could potentially be undertaken by an agency such as the Health Care Authority. The agency has experience in the field

of health insurance procurement, contracting for and working with actuarial consultants, and working with the Governor's Labor Relations Office in the collective bargaining context. HCA's involvement could also improve the State's ability to analyze the Trust's performance in light of current market conditions, risk data, and cost factors. HCA is a leader in health care policy, purchases quality health care and other benefits, and provides excellent service for its customers. Exploring and developing a competitive health insurance option to the Taft-Hartley Trust is not currently an HCA strategic initiative, or an initiative under the Governor's Government Management, Accountability, and Performance (GMAP) or Priorities of Government processes. The agency would need the appropriate funding to explore and develop options, including contracting for the actuarial and other expertise necessary to conduct this effort.

HCA programs include Basic Health, Community Health Services, and the Public Employees Benefits Board, and administration of the Uniform Medical Plan (UMP), the State's self-insured public employee health care option. HCA contracts with managed care plans to provide health care services to low-income state residents, public employees, and retirees. The HCA is the best resource available to the State to assess new ways to improve the quality of care and ensure cost-effective purchasing of health care services. Recent initiatives and projects in which their capacities have been used include:

- **Washington State Prescription Drug Project (PDP)** — The HCA/UMP, Department of Social and Health Services' Health and Recovery Services Administration, and Department of Labor and Industries signed an interagency agreement to coordinate drug purchasing, implement best practices, and reduce prescription drug costs for the three agencies. The PDP has provided evidence-based reviews on 24 drug classes, with two remaining for 2006. Cost savings among the three agencies in fiscal year (FY) 2005 was \$22.3M in state funds, with projected savings over \$29M in state funds in FY 2006.
- **Health Technology Assessment (HTA) program** — Implementation of this program, which was Governor's request legislation in 2006, will be launched through Calendar Year 2006 with the first three technologies identified for review by January 2007.
- **Health Data Warehouse** — HCA has joined and is working with the Puget Sound Health Alliance (PSHA) on a strategy for a community claims data warehouse with national performance metrics to measure provider performance. Based on a Joint Legislative Audit and Review Committee (JLARC) recommendation, HCA is proposing that Basic Health also develop claims data warehouse capabilities.

- **Health Care Purchasing** — HCA purchases health care coverage from private health plans for its Basic Health and Public Employees Benefits Board (PEBB) programs. PEBB procurement is a focus of the Governor's health care initiative to "Create a sustainable, affordable, quality system (state serving as a model)". HCA's procurement initiatives for 2007 assisted in achieving premium increases significantly under budget: 4.5% for Managed Care Organizations (MCO) and UMP with all benefit changes for active employees (budgeted at 8.5%), and a 3.5% projected premium increase for Medicare retirees (budgeted at 10%). A Value Plan option was also added, providing more choice for active enrollees.
- **Health Information Technology (HIT)** — Authorized by SSB 5064 in 2005, HCA has convened the Health Information Infrastructure Advisory Board to study and make recommendations regarding the State's role and activities in promoting and encouraging greater adoption of electronic medical records and health information technology in the health care industry. HCA has also partnered with three private entities (First Choice Health, Qualis Health, and Puget Sound Health Alliance) to provide up to \$1M in funds to small provider offices and rural hospitals for HIT adoption, enhancement, connectivity, or personal health records.

In July 2007, HCA will begin accepting applications for the Small Employer Health Insurance Partnership (SEHIP) program created in Chapter 255, Laws of 2006 (Chapter 70.47A RCW). The SEHIP program will provide premium subsidies for eligible employees of small employers (2-50 employees) who are enrolled in their employer-provided small group plans, and their dependents. This will benefit some of the agencies currently in need of premium reductions for their employees. The size limitation will, however, limit the number of agencies that can take advantage of this new plan. It will also be a problem for agencies whose employee numbers are somewhat changeable and those agencies seeking to grow in size.

In order to explore and create a marketable new product that could potentially insure all homecare workers, it would be necessary to allocate additional staff and resources to the Health Care Authority. The HCA has the expertise and industry experience working with actuarial consultants to fully explore possible alternative healthcare plans to address the needs of the homecare workforce and the State to find a more cost effective option. Such an exercise would need to include an evaluation of the costs to develop and implement alternatives. A statute change and funding would be necessary to make the option available.

Summary and Conclusions

Several scenarios brought up in the course of discussing this legislative proviso are no longer applicable. The Basic Health Plan is no longer an option, as the addition of the homecare workforce would have a major negative impact on the cost structure and thus on individuals already receiving insurance through this medium. It has also been suggested that the health care insurance reimbursement rate be converted and incorporated into the unit rate homecare agencies now receive. In light of parity, the rate calculation methodology needs to be examined carefully.

Mandated benefit levels will ensure a standard benefit for homecare workers and will put the State in a much better position to bargain costs as well as to obtain competitive pricing information from the healthcare industry. Likewise, mandating group pooling of non-union homecare agencies would better allow for the creation of a cost effective plan with a potentially higher level of benefits for the smaller agency workforce. With some investment of resources, it may be possible for the Health Care Authority to create a competitive alternative to the Trust that might expand the pool to include agencies not yet part of the Trust, and provide the state with a bargainable alternative.

Homecare health insurance rates are no longer determined legislatively but are bargained with SEIU. Because of the impact of parity legislation, all bargained wages and benefits for IPs will apply equally to all homecare agencies. Given their role in union negotiations, it is critical that DSHS and OFM inform and provide input if any new alternatives are to be developed or implemented.